

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
SM 9/60

(M)  
71

(I)  
2

MEDICAL CERTIFICATION

2

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>01936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01917</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <b>Harford County</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT A. ALEXANDER</b>				4. DATE OF DEATH Month Day Year <b>February 5, 1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/30</b>		9. AGE (In years last birthday) <b>31</b> Yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Trucking</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Auburn Alexander</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Reynolds</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-24-5160</b>				17. INFORMANT <b>Mrs. Robert A. Alexander, North East, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head and brain</b> DUE TO (b) <b>981X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in head</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2:55 Feb. 5, 1962</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Motel</b>			
20f. (City or town) <b>Edgewood, Maryland</b>				20g. (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Howard G. Shaub</b>				M.D. <b>HOWARD G. SHAUB, M. D.</b>				DATE SIGNED <b>2/6/62</b>			
EXAMINER'S NAME (Type) <b>JOSEPH R. GRANT</b>				Address (Street, city, town, or county) <b>North East, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-8-62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist Cem.</b>			
22d. LOCATION (City, town, or country) <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR <b>Joseph R. Grant</b>				24b. REGISTRAR'S SIGNATURE <b>Joseph R. Grant</b>			
23. FUNERAL DIRECTOR <b>Joseph R. Grant</b>				ADDRESS <b>North East, Maryland</b>				DATE <b>FEB 8 '62</b>			

71010

01930

1112 31

11/11/10

11/11/10

(M)

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

11/11/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01937

## CERTIFICATE OF DEATH

01918

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Ground</u> c. LENGTH OF STAY IN 1b <u>Dead on Arrival</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>US Army Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CONWAY</u> <u>BORUFF</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>13</u> Year <u>1962</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Cau</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>August 16, 1899</u>	<b>9. AGE</b> (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Officer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>US Army</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Claybourn, Nashville, Tenn.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Sampson Boruff</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Butcher</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WW1 &amp; WW 2</u>		<b>16. SOCIAL SECURITY NO.</b> <u>292-28-0183</u>		<b>17. INFORMANT</b> <u>Mrs. Ruth Boruff (Wife)</u> <u>Abingdon, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Massive</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Unk</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part f or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>19</u> <u>8:20 PM</u> <b>to</b> <u>19</u> <u>  </u> <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> <u>  </u> <b>and that death occurred at</b> <u>  </u> <b>M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Gariand White, Captain, MC US Army</u>		<b>22b. DATE SIGNED</b> <u>February 13, 1962</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>GARIAND WHITE, Captain, MC US Army</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE THEREOF</b> <u>2/15/1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Reeb Funeral Home</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Sylvania, Lucas Co., Ohio</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard K. McComas &amp; Son</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>Abingdon Maryland.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thane</u>					

81118

OFFICE OF THE SECRETARY OF THE ARMY

1913

(M)

Washington

and on

the following

the following

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01938

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01919

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> c. LENGTH OF STAY IN 1b <u>16 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Putnam Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> d. STREET ADDRESS <u>Putnam Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eugene Thomas Buckingham</u>				4. DATE OF DEATH <u>February 13 1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19, 1881</u>	
9. AGE (In years last birthday) <u>80 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		11. BIRTHPLACE (State or foreign country) <u>Howard County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Buckingham ?</u>				14. MOTHER'S MAIDEN NAME <u>Standiford ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>160-03-8009</u>		17. INFORMANT <u>Mrs. Louis O. Ford</u> Address <u>1827 E. Joppa Road Balto. 34, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Arteriosclerotic CVD disease</u> 422.2. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.			
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-13-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<u>Burial</u>		<u>2/19/1962</u>		<u>West Laurel</u>		<u>Philadelphia Pa.</u>	
23. FUNERAL DIRECTOR <u>Charles C. Kurtz</u> ADDRESS <u>Jarrettsville, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

C. 1910

6/12/2020

1910-1911



01939

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

INSTRUCTIONS

TO ATTEND

TO FUNERAL DIRECTOR

TO PHYSICIAN OR HOSPITAL

TO ATTEND

The bottom of the death certificate should be detached for use as a burial transit permit.

The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Harrietts Grace Rural</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Harrietts Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>Rural</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Charles E Chapman</u>				4. DATE OF DEATH <u>Feb 20 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>March 26 1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>65</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-14-18-5246</u>		17. INFORMANT & ADDRESS <u>Mrs. Charles Chapman</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.				18. MEDICAL CERTIFICATION			
3312 IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Generalized Arteriosclerosis</u>				5 yr			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Vascular Accident</u>				6 mo			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 9, 1950</u> , to <u>Feb 20, 1962</u> , that I last saw the deceased alive on <u>Feb 21, 1962</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dudley Phillips MD</u>				DATE SIGNED <u>2/22/62</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Feb 23, 1962</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Run</u>		LOCATION (City, town, or county) (State) <u>Harford Co, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H &amp; Bailey</u>		ADDRESS <u>Barlingstok</u>	
DATE <u>FEB 27 '62</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01940

01921

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EDGEWOOD</u> d. STREET ADDRESS <u>40 STARR ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>DONALD</u> <u>COULTER</u> <u>COULTER</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>FEB</u> <u>16</u> <u>1962</u>				
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>FEB. 16, 1962</u> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>9. AGE</b> (In years last birthday) yrs. <u>36</u> IF UNDER 1 YEAR Months Days Hours Min.			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>HARFORD CO. MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>DONALD COULTER</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>HELEN B. McROBERTS</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>754.5</u> DUE TO <u>(one chambered heart)</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/14, 1962</u> <b>to</b> <u>2/16, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/14, 1962</u> <b>and that death occurred at</b> <u>1:05 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>[Signature]</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/16/62</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <u>2/16/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>HARFORD MEM. HOSPITAL</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>HAVRE DE GRACE, MD.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>25a. REC'D BY REGISTRAR</b> <u>501 S. Union Ave.</u> <u>Havre de Grace, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Fries</u>			
<b>DATE</b> <u>FEB 26 '62</u>							

2071326122

15610

000000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01941

01922

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harvre de Grace</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Street</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>W.</u> Last <u>Cullum</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STONE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ARCHER CULLUM</u>	
14. MOTHER'S MAIDEN NAME <u>LAVANIA BULL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-10-8892</u>		17. INFORMANT <u>MRS. GRACE CULLUM, STREET, MD.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant melanoma</u> DUE TO (b) <u>190.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 18, 1947</u> to <u>Feb 26, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 25, 1962</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Sudley Phillips M.D.</u>		22b. DATE SIGNED <u>2/26/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sudley Phillips</u>		22d. ADDRESS <u>Darlington Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-2-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ASCENSION</u>		23d. LOCATION (City, town or county) (State) <u>SCARBORO, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

M

24010

SSe 10

## CERTIFICATE OF DEATH

Reg. Dist. No. 01923

01942

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Street</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cherry Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmo</b> Middle <b>Dick</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	11. BIRTHPLACE (State or foreign country) <b>Street, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Dick</b>	
14. MOTHER'S MAIDEN NAME <b>Ruth Moore</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Willard Dick</b> Address <b>Cardiff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2-24-62</b> , 19____, to <b>2-24-62</b> , 19____, that I last saw the deceased alive on <b>2-24-62</b> , 19____, and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2-24-62</b> DATE SIGNED ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer M.D. Bel Air, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>		22d. LOCATION (City, town, or county) (State) <b>Street, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Hudson</b> ADDRESS <b>Delta, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 1 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles L. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 10023

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		DATE OF BIRTH [Faint text, possibly "10-15-1900"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "10-20-1950"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. 10023		COUNTY OF BALTIMORE		STATE OF MARYLAND	

10023

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same shall be sent to the local health officer of the county in which the death occurred.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01943  
CERTIFICATE OF DEATH  
01924

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALE DE GRACE</b>		c. LENGTH OF STAY IN b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CARDIFF</b>			
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>			
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>GERALD V. EATON</b>				4. DATE OF DEATH <b>FEBRUARY 24 1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 25, 1913</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>8</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILLWORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SLATE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>STEWARTSTOWN, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifton Eaton</b>				14. MOTHER'S MAIDEN NAME <b>MARY BURKINS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give view or del of service) <b>215-07-9102</b>		17. INFORMANT <b>MRS. ALICE EATON, CARDIFF, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420-1</b> DUE TO <b>CORONARY Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
2Dc. TIME OF INJURY Hour <b>19</b> a.m. <b>19</b> p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 23 1962</b> to <b>FEB 24 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 23 1962</b> and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dudley Phillips MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-24-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>				22d. ADDRESS <b>DARLINGTON MARYLAND</b>			
23a. BURIAL, CREMATION, or other method of disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-27-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS</b>		23d. LOCATION (City, town or county) (State) <b>PLESVILLE MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Hawkins, DELTA, PA.</b>				ADDRESS <b>DELTA, PA.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 1 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>			

18010

83010

(M)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1941" and "C. ... V. ..." are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

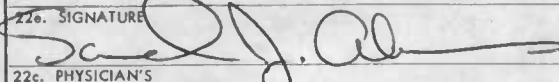
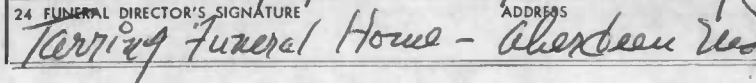

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01944

01925

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Harford</b> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			c. LENGTH OF STAY IN 1b <b>23 hrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US Army Hospital Aberdeen PG Md</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Aberdeen</b>		
			d. STREET ADDRESS <b>Route # 1</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>HILTON</b> Middle <b>CLAY</b> Last <b>FARMER</b>			<b>4. DATE OF DEATH</b> Month <b>Feb</b> Day <b>27</b> Year <b>19 62</b>		
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>29 Aug 1909</b>		<b>9. AGE</b> (In years last birthday) <b>52 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>27</b> Days <b>19</b> Hours <b>62</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Ash, North Carolina</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>James P Farmer</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Myra E Sapp</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>186-14-7466</b>		<b>17. INFORMANT</b> <b>Mrs Elizabeth Farmer (Wife) same as 2 above</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Increased intracerebral pressure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>producing respiratory arrest and cardiac arrest</b> DUE TO <b>injury (missile) to brain</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>23 hours</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Small missile penetrated skull (nail from power tool)</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>10:30</b> e.m. <b>Feb 26 19 62</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Work</b>	
<b>20f. (City or town)</b> <b>Aberdeen PG</b>		<b>(County)</b> <b>Harford</b>		<b>(State)</b> <b>Md</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Feb 26, 1962 to Feb 27, 1962, that (we) last saw the deceased alive on Feb 27, 1962, and that death occurred 10A.M. from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> 		<b>22b. DATE SIGNED</b> <b>27 Feb 62</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>SAMUEL J ABRAMS</b>	
<b>22d. ADDRESS</b> <b>US Army Hospital Aberdeen PG Md</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/2/1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Highland Presbyterian</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Street, Maryland</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> 		<b>25a. REC'D BY REGISTRAR</b> <b>5 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 	

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

01925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01945 CERTIFICATE OF DEATH 01926

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>	
c. LENGTH OF STAY IN TB <b>3 days</b>		d. STREET ADDRESS <b>169 Bloomsbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George S</b>		DATE OF DEATH <b>FEBRUARY 10 1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 3, 1893</b>	
9. AGE (In years) <b>69</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Cargo Foreman</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Unknown Helen L. Groak, 169 Bloomsbury Ave. Harford State Me.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>204.3</b>		DUE TO <b>Acute Lymphatic Leukemia</b>	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>204.3</b>		DUE TO <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 7th 1962</b> to <b>Feb 10th 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 10th 1962</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward C. Loo</b>		22b. DATE SIGNED <b>Feb 10th 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		22d. ADDRESS <b>Haure de Grace, Ind.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/13/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		23d. LOCATION (City, town or county) (State) <b>Haure de Grace, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anthony L. Pina</b>		25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony L. Pina</b>		25c. DATE	



2520

32820

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01946

## CERTIFICATE OF DEATH

01927

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>441 Moore's Mill Road</b>		d. STREET ADDRESS <b>441 Moore's Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>William Brierly Gross</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>15</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1926</b>
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Utility Company</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benton H. Gross, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Wright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. #2 213-20-6792</b>	
17. INFORMANT (Wife) <b>Mrs. Kathryn M. Gross</b>		Address <b>441 Moores Mill Bel Air, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA</b> (c) <b>CARCINOMA OF URACHUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>6 MONTHS</b> <b>2 1/2 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> to <b>15 FEB 1962</b> that (I) (we) last saw the deceased alive on <b>15 FEB 1962</b> , and that death occurred at <b>7:30 P.M.</b> the causes and on the date stated above.			
22a. SIGNATURE <b>H.P. Sidwell M.D.</b>		22b. DATE SIGNED <b>15 FEB 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.P. SIDWELL M.D.</b>		22d. ADDRESS <b>401 FRANKLIN ST. BEL AIR, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Bel Air, Harf. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>		25a. REC'D BY REGISTRAR <b>FEB 20 62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland</b>	

VR A15 (4)  
15M 9/60

Joseph W. Foster

5210

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01947

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01928

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> c. LENGTH OF STAY IN 1b <u>9 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> d. STREET ADDRESS <u>Route # 1 Box 32</u> e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irene Bagley Harbaugh</u> First Last				4. DATE OF DEATH <u>February 27 1962</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1884</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Charles Bagley</u>			14. MOTHER'S MAIDEN NAME <u>Ella Mc Cauley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-6731</u>		17. INFORMANT <u>Frank C. Harbaugh</u> Address <u>Joppa Md.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>Bella A. in, md.</u> DATE SIGNED <u>2-25-62</u> ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 3, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or country) (State) <u>Joppa, Harford, Maryland</u>			
23. FUNERAL DIRECTOR <u>Howard K. Mc Comas &amp; Son</u> Abingdon, Md.,		24a. REC'D BY REGISTRAR <u>MAR 5 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. House</u>			

01328

01047

272

Jan. 2, 1934

Truman

Charles J. ...

Frank G. ...

1934

Union ...

3rd ...

Abington, Mass.

Gov. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 1 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01948

## CERTIFICATE OF DEATH

01929

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b> c. LENGTH OF STAY IN 1b <b>46 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Grier Nursery Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b> d. STREET ADDRESS <b>Grier Nursery Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Hyle Harward</b>		4. DATE OF DEATH <b>February 15, 1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Walter H. Harward</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-3253</b>	
17. INFORMANT (Sister) <b>Mrs. David Preston</b>		Address <b>Grier Nurs. Rd. Forest Hill, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420 DUE TO (b) <b>coronary thromboses</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>moderate pulmonary emphysema &amp; fibrosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx 10 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/27, 1962</b> to <b>2/15, 1962</b> that (I) (we) last saw the deceased alive on <b>2/15, 1962</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Warren R. Lesch, M.D.</b>		22b. DATE SIGNED <b>2/16/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Warren R. Lesch, M.D.</b>		22d. ADDRESS <b>202 S. Main Street, Bel Air, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Hickory, Harf. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>		25a. REC'D BY REGISTRAR <b>FEB 20 '62</b>	
ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

FOSTER FUNERAL HOME  
W. BROADWAY & WILLIAMS  
BEL AIR, MD.



2000

2224

M

28 4021 117.100

[illegible]

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01949

## CERTIFICATE OF DEATH

01930

Items 8, 9, 10a & 10b, Film G-308 3/1/62.cac.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HARVE &amp; GRACE</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD MEMORIAL HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X STREET</b> d. STREET ADDRESS <b>1 Davis Corner Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARY Ruth HOLBROOK</b>			4. DATE OF DEATH <b>Feb. 26 1962</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 11 1934 1935</b>	9. AGE (In years last birthday) <b>27 26</b> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator Electrical</b>			11. BIRTHPLACE (County & State, or foreign country) <b>M.D. U.S.A.</b>		
13. FATHER'S NAME <b>WILBUR HARRIS</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET RITZ</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-34-6729</b>		
17. INFORMANT (Husband) <b>Avery Dwight Holbrook</b>			Address <b>RFB 2, Box 24 Street, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Chremia and Acidosis</b> <b>600.0</b> DUE TO <b>Transfusion Reaction and a Severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Chronic Pyelonephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Secondary Anemia for Pyelonephritis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>36hr</b> <b>36hr</b> <b>5yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 57</b> to <b>Feb 26 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 25 1962</b> and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Dudley Phillips MD</b>			22b. DATE SIGNED <b>2/24/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 28, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR MEMORIAL GARDENS</b>
23d. LOCATION (City, town or county) <b>BEL AIR, Harford Co., Maryland</b>			(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>			25a. REC'D BY REGISTRAR <b>FEB 27 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>
25c. ADDRESS <b>W. Broadway and Williams St. Bel Air, Maryland</b>					

Joseph W. Foster

0190

0190

HARPER

MARYLAND

HARPER

THOMAS & GEORGE

HARPER'S MEMORIAL

MARY KATH

F W

MARY KATH

U.S.A.

M.D.

HARPER

WILBUR

MARGARET

RITZ

STREET, NEW YORK

STREET, NEW YORK

THE HARPER MEMORIAL

STREET, NEW YORK

STREET, NEW YORK

STREET, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01950

01931

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shesdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shesdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>438 Edmund Street</u>		d. STREET ADDRESS <u>438 Edmund Street</u>	
3. NAME OF DECEASED (Type or print) <u>Sadie Elizabeth Hubbard</u>		4. DATE OF DEATH <u>2</u> <u>4</u> <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Josiah Hardy</u>		14. MOTHER'S MARRIED NAME <u>Gertrude Moulton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-26-3634</u>	
17. INFORMANT <u>Gloria Weddle</u>		Address <u>438 Edmund St. Shesdeen</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Shesdeen</u>		(County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> to <u>2/3</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3, 1962</u> , and that death occurred at <u>100A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>529 Revolution St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/8/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City, town or county) <u>Shesdeen, Rural Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring - Shesdeen, Maryland</u>		25. REC'D BY REGISTRAR <u>FEB 7 '62</u>	
ADDRESS <u>Shesdeen, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

M

01050

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

01051

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

Harf one

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1  
#  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01932

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood R.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Edgewood R.D. Box 13</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bones Farm</u>				d. STREET ADDRESS <u>1 Jones Farm</u>			
3. NAME OF DECEASED (Type or print) <u>Reed</u> First <u>Hudson</u> Middle <u>✓</u> Last				4. DATE OF DEATH <u>February 10 19 62</u> Month <u>10</u> Day <u>19</u> Year <u>62</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1913</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>✓</u> Days <u>✓</u>		IF UNDER 24 HRS. Hours <u>✓</u> Min. <u>✓</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Darlington, S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW 11</u>		17. INFORMANT <u>Margaret Hudson</u>		Address <u>Edgewood R.D., Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic disease</u>							
422.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Lorald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <u>Bel Air, md.</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer-MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-10-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb 13, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	
22d. LOCATION (City, town, or country) (State) <u>Abingdon, Harford, Maryland</u>							
23. FUNERAL DIRECTOR'S NAME (Type) <u>Howard K. Mc Comas &amp; Son</u>				24a. REC'D BY REGISTRAR <u>Feb 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



01021

01021



D. Box 12

D.

Nov. 10, 1913

Washington, D.C.

Dear Sir

Dear Sir

Enclosed

Enclosed

Very respectfully,  
Your obedient servant,  
[Signature]

10-10-13

Very truly yours,

Very truly yours,

John D. [Signature]

John D. [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01952

01933

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Bel Air</b>		c. LENGTH OF STAY IN 1b <b>58 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Toll Gate Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Bel Air</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth May Joesting</b>		d. STREET ADDRESS <b>Toll Gate Road</b>	
4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1962</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1871</b>
9. AGE (In years last birthday) <b>90 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>S. A. Foutz</b>		14. MOTHER'S MAIDEN NAME <b>Miriam Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT (Son) <b>John F. Joesting</b>		Address <b>R.F.D. #1 Bel Air, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-17</b> , 19 <b>62</b> to <b>2-5</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>2-4</b> , 19 <b>62</b> , and that death occurred at <b>14</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Gerald C. Palmer</b>		22b. DATE SIGNED <b>2-5-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer, M. D.</b>		22d. ADDRESS <b>S. Main Street, Bel Air, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Bel Air, Harf. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 6 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

Joseph W. Foster

01333

01332

(M)

RECEIVED  
OFFICE OF THE  
ATTORNEY GENERAL  
WASHINGTON, D. C.  
JAN 10 1961

U. S. DEPT. OF JUSTICE  
WASHINGTON, D. C.  
JAN 10 1961

RECEIVED  
OFFICE OF THE  
ATTORNEY GENERAL  
WASHINGTON, D. C.  
JAN 10 1961

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01953

## CERTIFICATE OF DEATH

Reg. Dist. No. 01934

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Forest Hill</i>		c. LENGTH OF STAY IN 1b <i>87 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>SAYANNAH</i> Middle <i>JOHNSON</i> Last		4. DATE OF DEATH Month <i>Feb.</i> Day <i>19</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 4, 1875</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Chestnut Hill, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James A. Ward</i>		14. MOTHER'S MAIDEN NAME <i>Virginia J. Mc Laughlin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>James M. Johnson</i> Address <i>Forest Hill, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334-X</i> DUE TO <i>CARDIO-RESP. FAILURE</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>ADVANCED ARTERIOSCLEROSIS</i> (c) <i>6 Mo</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CONGESTIVE HEART FAILURE + STROKE 3YRS AGO</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>18 FEB</i> , 19 <i>61</i> , to <i>18 FEB</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>18 FEB</i> , 19 <i>61</i> , and that death occurred at <i>6:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. P. Sidwell MD</i>		DATE SIGNED <i>19 FEB 1962</i>	
PHYSICIAN'S NAME (Type) <i>H. P. SIDWELL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/21/62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Overbrook</i>		22d. LOCATION (City, town, or county) (State) <i>Chestnut Hill, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kuntz</i> ADDRESS <i>Jarrettsville, Md.</i>		24a. REC'D BY REGISTRAR <i>Feb 23 '62</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Kuntz</i>	

1931

CENTRAL BANK OF AMERICA

1931

(M)

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "BANK" and "AMERICA" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01954

## CERTIFICATE OF DEATH

01935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - BEL AIR</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Bel Air</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS <b>RD #2, Box 216</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>KLEIN</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3, 1884</b>		9. AGE (In years lost birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mason, Stone</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Masonry</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Klein</b>				14. MOTHER'S MAIDEN NAME <b>Anna Zinkhan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>219-03-4163</b>		17. INFORMANT <b>Mrs. Kenneth Davis</b> Address <b>Box 216 RD #2 Bel Air, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 hours</b> <b>10 or more years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15, 1954</b> , to <b>February 12, 1962</b> , that I last saw the deceased alive on <b>February 12, 1962</b> , and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul S. Stonesifer Jr.</b>				ADDRESS (Street, city or town, state) <b>115 Fulford Ave.,</b>		DATE SIGNED <b>2/12/62</b>	
PHYSICIAN'S NAME (Type) <b>PAUL S. STONESIFER JR., M. D.</b>				Bel Air, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jarrettsville</b>		22d. LOCATION (City, town, or county) (State) <b>Jarrettsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kurtz</b>				ADDRESS <b>Jarrettsville, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 14 '62</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

M

I

0

1

of





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01955

## CERTIFICATE OF DEATH

01936

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Rocks</u>		<u>50 years</u>		TOWN <u>Rural Rocks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Knopp Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>HENRIETTA</u> (Middle) <u>REYNOLDS</u> (Last) <u>KNOPP</u>				(Month) <u>FEB</u> (Day) <u>20</u> (Year) <u>1962</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 10, 1882</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Chrome Hill, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Harman Ira Reynolds</u>				<u>Mary Truman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>218-14-5604</u>		<u>Harry C. Knopp Rocks, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>The Meningitis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Pulmonary The</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Diabetes Mellitus</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>2 1/2 mos.</u>			
				<u>Prob. 1 yr.</u>			
				<u>12 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/20, 1950</u> , to <u>2/20, 1962</u> , that I last saw the deceased alive on <u>2/15, 1962</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Chrome Hill Md.</u> DATE SIGNED <u>2/20/62</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/22/1962</u>		<u>William Watters</u>		<u>Cooptown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Charles E. Kurtz</u>		<u>Charles E. Kurtz</u>		<u>Jarrettsville, Md.</u>	
DATE <u>FEB 23 '62</u>							

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the health department as soon as possible. It is the responsibility of the physician or other qualified person to ensure that the information is accurate and complete. The form should be filled out in ink, and should be signed by the physician or other qualified person. The form should be submitted to the health department, and a copy should be retained by the physician or other qualified person. The form should be filled out for all deaths, except those which are due to natural causes and which are not reportable. The form should be filled out for all deaths, except those which are due to natural causes and which are not reportable. The form should be filled out for all deaths, except those which are due to natural causes and which are not reportable.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		M		45		1910		NEW YORK		DRUGGIST		HEART DISEASE		HOME		10:00 AM		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF FUNERAL HOME		17. NAME OF FUNERAL HOME		18. NAME OF FUNERAL HOME		19. NAME OF FUNERAL HOME		20. NAME OF FUNERAL HOME		21. NAME OF FUNERAL HOME		22. NAME OF FUNERAL HOME		23. NAME OF FUNERAL HOME		24. NAME OF FUNERAL HOME	
CATHOLIC CHURCH		JAMES H. HARRIS		1910		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

01038

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01956

## CERTIFICATE OF DEATH

01937

Item 13 Film G308 3/5/62 jwk

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>	
c. LENGTH OF STAY in 1b <b>3 DAYS</b>		d. STREET ADDRESS <b>*1 Horseshoe Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD MEMORIAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Scott MACE</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 26 1962</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 10, 1908</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wyoming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emory Allen Scott</b>		14. MOTHER'S MAIDEN NAME <b>Amy REESE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>089-03-8956</b>		16. SOCIAL SECURITY NO. <b>089-03-8956</b>	
17. INFORMANT <b>W.E. Mace</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> 415X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic myocarditis</b> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6</b> <b>1961</b> to <b>2/27</b> , <b>1962</b> that (I) (we) last saw the deceased alive on <b>2/26</b> , <b>1962</b> , and that death occurred at <b>11:35</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Neil Taylor, M.D.</b>		22b. DATE SIGNED <b>2/27/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Neil Taylor, M.D.</b>		22d. ADDRESS <b>Rising Sun, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/2/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		23d. LOCATION (City, town or county) (State) <b>Cecilia Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed, Rising Sun, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

(M)

01252

Winfred

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

Winfred

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

Winfred

Winfred & Ethel

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

Winfred

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

01337

Winfred

Winfred

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

Winfred

Winfred & Ethel

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

Winfred

John & Grace

Winfred & Ethel

Ethel

Female white

House wife

VS. AISME  
SM 9/60

## 01938

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Harford</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Benson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>at Home</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <b>Benson</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Preston Lee Magness, Sr.</b> 5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b> 8b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b> 9. FATHER'S NAME <b>Ramsay Lee Magness</b> 10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>215-03-2973</b> 11. SOCIAL SECURITY NO. <b>215-03-2973</b> 12. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 13a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 13b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 13.) 13c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 13d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 13e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 13f. (City or town) (County) (State) 14. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Lernold C Palmer</b> M.D. EXAMINER'S NAME (Type) <b>Gerald C. Palmer M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Bel Air, Md.</b> Address (Street, city, town, or county)		4. DATE OF DEATH <b>February 23</b> 19 <b>62</b> 5. AGE (in years last birthday) <b>59</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 YRS. Hours Min. 6. BIRTHPLACE (State or foreign country) <b>Harford County, Maryland</b> 7. CITIZEN OF WHAT COUNTRY? <b>US</b> 8. MOTHER'S MAIDEN NAME <b>Carrie Stoffer</b> 9. INFORMANT <b>Mrs. Carrie Magness</b> Address <b>Benson, Md</b> 10. INTERVAL BETWEEN ONSET AND DEATH 11. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>22. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23. FUNERAL DIRECTOR</b> <b>W. H. ARCHER</b> <b>24. REC'D BY REGISTRAR</b> <b>W. H. ARCHER</b> <b>25. DATE</b> <b>February 26, 1962</b> <b>26. LOCATION (City, town, or country)</b> <b>Mountain Christian</b> <b>27. REGISTRAR'S SIGNATURE</b> <b>Benson, Md.</b> <b>28. DATE</b> <b>Joppa, Maryland</b> <b>29. REGISTRAR'S SIGNATURE</b> <b>Bel Air, Md.</b> <b>30. DATE</b> <b>March 1 '62</b>		<b>22. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23. FUNERAL DIRECTOR</b> <b>W. H. ARCHER</b> <b>24. REC'D BY REGISTRAR</b> <b>W. H. ARCHER</b> <b>25. DATE</b> <b>February 26, 1962</b> <b>26. LOCATION (City, town, or country)</b> <b>Mountain Christian</b> <b>27. REGISTRAR'S SIGNATURE</b> <b>Benson, Md.</b> <b>28. DATE</b> <b>Joppa, Maryland</b> <b>29. REGISTRAR'S SIGNATURE</b> <b>Bel Air, Md.</b> <b>30. DATE</b> <b>March 1 '62</b>	



01338

01337

100-111111  
100-111111



Person

Person

02

02

Person, 100-111111

January 15, 1903

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111

Person, 100-111111



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01939

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman D. Massey</u>				4. DATE OF DEATH Month Day Year <u>February 5 19 62</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 15 1903</u> 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN MASSEY</u>				14. MOTHER'S MAIDEN NAME <u>INDIANA SATTERFIELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>218-10-4549</u>		17. INFORMANT <u>MRS. ANNA MASSEY - BELCAMP MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2-562</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 7</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR <u>Edgar L. Lane - Church Hill, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

9201.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01959

## CERTIFICATE OF DEATH

Reg. Dist. No.

01940

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>17 Mc Cann</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David B. Mc Daniel</u>				4. DATE OF DEATH Month Day Year <u>Feb. 14 19 62</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>		11. BIRTHPLACE (State or foreign country) <u>Rockwood, Tenn.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Joseph Mc Daniel</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Mc Gee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>400-09-3321</u>		17. INFORMANT <u>Everett Mc Daniel</u>		Address <u>Corbin, Ky.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia, Tuberculosis</u> DUE TO (c) <u>Anemia, Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 9</u> , 19 <u>60</u> , to <u>Sept 14</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>62</u> , and that death occurred at <u>10:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D.				ADDRESS (Street, city or town, state) <u>Edgewood Maryland</u>		DATE SIGNED <u>Feb. 14, 1962</u>	
PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u>				<u>Edgewood Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 17, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Mc Comas &amp; Son</u>				ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 20 '62</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kahan</u>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>RESIDENCE</p>		<p>PLACE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>DATE OF BIRTH</p>		<p>TIME OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>DIAGNOSIS</p>	
<p>DATE OF EXAMINATION</p>		<p>PLACE OF EXAMINATION</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	

M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01960

CERTIFICATE OF DEATH

Reg. Dist. No. 01941

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Darlington</b>				c. LENGTH OF STAY IN 1b <b>35 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Darlington</b>				d. STREET ADDRESS <b>Dublin</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dublin</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANITA COOPER MCKNIGHT</b>				4. DATE OF DEATH Month Day Year <b>Feb. 19 1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1926</b>		9. AGE (In years last birthday) <b>35 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Belair, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Don P. McKnight</b>				14. MOTHER'S MAIDEN NAME <b>Zollie Tompkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Zollie T. McKnight, Darlington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - VIRAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/18</b> , 19 <b>62</b> , to <b>2/19</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>2/19</b> , 19 <b>62</b> , and that death occurred at <b>230P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Darlington, Md.</b> DATE SIGNED <b>2/20/62</b> ACTUAL SIGNATURE <b>Dudley Phillips</b> M.D. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Belair, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Haskins</b> Address <b>Delta, Pa.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 26 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
Baltimore, Md.

**CERTIFICATE OF DEATH**

1. Name of deceased: JOHN J. HENRY

2. Sex: Male

3. Age: 45

4. Date of birth: 1915

5. Place of birth: NEW YORK

6. Date of death: 1960

7. Time of death: 10:00 AM

8. Cause of death: HEART DISEASE

9. Place of death: HOME

10. Signature of physician: [Signature]

11. Signature of registrar: [Signature]

12. Signature of informant: [Signature]

13. Name of informant: JOHN J. HENRY

14. Address of informant: 1234 MAIN ST. BALTIMORE, MD.

15. Date of filing: 1960

16. File number: 123456

17. Registrar's name: JOHN J. HENRY

18. Registrar's address: 1234 MAIN ST. BALTIMORE, MD.

19. Registrar's phone: 123-4567

20. Registrar's signature: [Signature]

21. Registrar's title: REGISTRAR

22. Registrar's commission expires: 1965

23. Registrar's seal: [Seal]

24. Registrar's stamp: [Stamp]

25. Registrar's license: 123456

26. Registrar's registration: 123456

27. Registrar's certificate: 123456

28. Registrar's record: 123456

29. Registrar's index: 123456

30. Registrar's file: 123456

31. Registrar's folder: 123456

32. Registrar's box: 123456

33. Registrar's cabinet: 123456

34. Registrar's room: 123456

35. Registrar's building: 123456

36. Registrar's city: BALTIMORE

37. Registrar's state: MARYLAND

38. Registrar's country: UNITED STATES OF AMERICA

39. Registrar's continent: AMERICA

40. Registrar's world: WORLD

41. Registrar's universe: UNIVERSE

42. Registrar's cosmos: COSMOS

43. Registrar's galaxy: GALAXY

44. Registrar's solar system: SOLAR SYSTEM

45. Registrar's planet: PLANET

46. Registrar's moon: MOON

47. Registrar's star: STAR

48. Registrar's sun: SUN

49. Registrar's galaxy: GALAXY

50. Registrar's universe: UNIVERSE

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Home do trace</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Street</u>		d. STREET ADDRESS <u>Box 332</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Lee Messick</u>				4. DATE OF DEATH Month Day Year <u>February 3 1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 1942</u>	9. AGE (In years last birthday) <u>19 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Bata shoe factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Carroll P. Messick</u>		14. MOTHER'S MAIDEN NAME <u>Alice Hodson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-40-2129</u>		17. INFORMANT <u>Carroll Messick</u> Address <u>Street, Md. Box 332</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2-3</u> <u>1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Fountain Green</u>		20f. (City or town) (County) (State) <u>Bel Air Harford Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Lowell C Palmer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		Address (Street, city, town, or county) <u>2-3-62</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 6, 1962</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Cecil Co Md</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>H &amp; Bailey</u>		ADDRESS <u>Stearlington Md</u>		24a. REC'D BY REGISTRAR <u>FEB 8 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thoma</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1945

1945

M



1945

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01962

## CERTIFICATE OF DEATH

01943

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				d. STREET ADDRESS <u>723 Otsego</u>			
3. NAME OF DECEASED (Type or print) <u>Arthur V. Mitchell</u>				4. DATE OF DEATH <u>2/28/62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/1877</u>	
9. AGE (In years last birthday) <u>84</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Perm. P. R.</u>			
13. FATHER'S NAME <u>George V. Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Courtney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Gina C. Mitchell</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> 4-4-2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral</u> (c) <u>Cerebral</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-1-62</u> to <u>2/28/62</u> , that (I) (we) last saw the deceased alive on <u>2/28/62</u> and that death occurred at <u>19</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grove</u>		23d. LOCATION (City, town or county) (State) <u>Chesapeake Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Purinton &amp; Son, Harford</u>				25a. REC'D BY REGISTRAR <u>5 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

01810

01803



*[Faint, mirrored handwriting, likely bleed-through from the reverse side of the page. The text is illegible due to fading and mirroring.]*



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01944

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u> c. LENGTH OF STAY IN 1b <u>6/30/1961</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford County House</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Sherdeem</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>O.</u> Last <u>Moody</u>			4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1962</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 31-1888</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Oliver</u>		14. MOTHER'S MAIDEN NAME <u>house Elsner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Ralph Moody - Sherdeem #1-nd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma breast with metastases</u> DUE TO (b) <u>170 X</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, nd.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2-9-62</u>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	
22d. LOCATION (City, town, or country) (State) <u>R.D. Bel Air, Maryland</u>		23. FUNERAL DIRECTOR <u>Tanning Funeral Home</u> <u>Berdeen, Md.</u>			
24a. REC'D BY REGISTRAR <u>DATE FEB 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

01014

61263

Thompson, the  
Madden

the first of the  
perfect count down

James O. Moody

July 1-1915

James O. Moody

USA

Thompson

James

James

James Elston

William Oliver

Ralph Moody - Aberdeen #1-100

Caroline was with

X

X

Bell, in

James E. Bell

James E. Bell

2-2-2

Wm. J. Bell

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

<div> <div>Item 20b 1-1m 307</div> <div>2-14-62 ams</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>01964</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01945</div> </div>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Hartford</i>						a. STATE <i>MD</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						b. COUNTY <i>Hartford</i>					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Hartford D O A</i>						<i>X Aberdeen</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
<i>Hartford Memorial Hospital</i>						<i>19 D 1</i>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
<i>Joseph Lester Nelson</i>						<i>February 3 19 62</i>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<i>M</i>		<i>W</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Sept. 25-1944</i>		<i>17 yrs.</i>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
<i>Wachusett (Printer)</i>				<i>Boys Shoe Co.</i>				<i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME					
<i>U.S.A.</i>						<i>Lester Lee Nelson</i>					
14. MOTHER'S MAIDEN NAME						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					
<i>Ada Annie Brooks nee</i>						<i>219-40-7482</i>					
16. SOCIAL SECURITY NO.						17. INFORMANT					
<i>219-40-7482</i>						<i>James E. Hart</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH					
<i>825X Fracture Skull</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<i>Fracture R femur compound</i>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
						<i>Auto accident</i>					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	
<i>3:30 a.m. 2-3 1962</i>				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<i>Fountain Green</i>		<i>Bel Air</i>		<i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gerald E Palmer</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, MD</i>					
EXAMINER'S NAME (Type) <i>Gerald E Palmer MD</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>2-3-62</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<i>Burial</i>						<i>Feb 6th 1962</i>		<i>St. John Cemetery</i>		<i>Bel Air, Rural Maryland</i>	
23. FUNERAL DIRECTOR						24a. REC'D BY REGISTRAR					
<i>John F. Sarring - Aberdeen Maryland</i>						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>					

01915

(M)

Handwritten text, likely a letter or document, containing several lines of cursive script. The text is mirrored across the page, suggesting a bleed-through from the reverse side. Legible fragments include "Handwritten (cursive)", "for the", "The House", and "from E. Hart".

Handwritten text at the bottom of the page, appearing to be a signature or a closing line. It is mirrored across the page. Legible fragments include "The House" and "from E. Hart".

1  
M  
50  
I  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01965

01946

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b> c. LENGTH OF STAY IN 1b <b>12 FEB 62-DEATH</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US ARMY HOSPITAL-APC, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CONOWINGO</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b> First Middle Last <b>(NONE) RATCLIFFE</b>		4. DATE OF DEATH <b>FEB 18 1962</b> Month Day Year		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>18 APR 1913</b> 9. AGE (In years last birthday) <b>48</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b> 11. BIRTHPLACE (County & State, or foreign country) <b>ROWLANDSVILLE, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>SAMUEL MACCAULEY</b> 14. MOTHER'S MAIDEN NAME <b>BERTHEAOTTEL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>219-07-3262</b> 17. INFORMANT <b>J. RATCLIFFE-HUSB</b> Address <b>Rising Sun, Md.</b> PH. # <b>36F5</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic cancer</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>adenocarcinoma of cervix</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <b>2-11</b> (this hospital) attended the deceased from <b>1962</b> to <b>1962</b> , that <b>2-18</b> (we) last saw the deceased alive on <b>2-18</b> , 19 <b>62</b> , and that death occurred at <b>1:30</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas J. Fraker</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/21/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>			
23d. LOCATION (City, town or county) <b>Coloma</b>		(State) <b>Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M. Peck</b>		ADDRESS <b>Rising Sun, Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 21 '62</b> 25b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>			



01016

CHURCH OF JESUS

01062

(M)

1954/1955

1954/1955 (continued)

None

12 Army Hospital, H.P. India

18 Oct

1954

(1954) 1954/1955

1954/1955

1954/1955

1954/1955

1954/1955

1954/1955

1954/1955

1954/1955

1954

1954/1955

1954

1954/1955

1954/1955

1954

1954

1954

1954

1954

1954/1955

1954

1954

1954/1955

1954/1955





01917

01968

(M)

John's collection - Virginia Islands

John's collection - Virginia Islands

John's collection - Virginia Islands

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M 71

I

0

1

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01967

01948

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28 Aberdeen</u>		d. STREET ADDRESS <u>45 Monroe Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1901</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-01-8635</u>		17. INFORMANT <u>Hospital Record.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>26 OX</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Diabetes Mellitus with Mild Acidosis</u> DUE TO (c) <u>Hypertensive Cardio Renal disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> <u>1962</u> to <u>2/1</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> <u>1962</u> , and that death occurred at <u>6:40</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution St. Haure de Grace, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-8-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Aberdeen, Harford Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia S. Bullock - Haure de Grace, Md.</u>				25a. REC'D BY REGISTRAR <u>13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

01913

01913

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01968

01949

<b>1. PLACE OF DEATH</b> e. COUNTY <i>Harford</i> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>				c. LENGTH OF STAY in lb <i>10 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hospital</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>			
d. STREET ADDRESS <i>502 Rock Spring Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>James W. Wagg</i>				<b>4. DATE OF DEATH</b> Month Day Year <i>Feb 18 1962</i>			
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>White</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>Mar. 1, 1885</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Home Construction</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Virginia</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Alfred Wagg</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Louise Ross</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <i>no</i>				<b>16. SOCIAL SECURITY NO.</b> <i>215-03-2957</i>		<b>17. INFORMANT</b> Address <i>J. Alma Wagg, 502 Rock Spring Ave., Bel Air, Md.</i>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>3-4 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <i>1 Pneumonia, right lower lobe</i> (b) <i>2 Senility</i> (c) <i>3 Malnutrition</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Feb. 8th 1962</i> <b>to</b> <i>Feb. 18th 1962</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Feb. 18th 1962</i> <b>and that death occurred at</b> <i>8:30 A.M.</i> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Edward C. Loo, M.D.</i>				<b>22b. ADDRESS</b> <i>Havre de Grace, Md.</i>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>Edward C. Loo, M.D.</i>				<b>22d. DATE SIGNED</b> <i>2/18/62</i>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>Feb. 21, 1962</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Mt. Zion</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>Bel Air, Harford, Maryland</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Howard K. Mc Comas &amp; Son</i>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Cuthbert L. Thomas</i>			
<b>ADDRESS</b> <i>Howard K. Mc Comas &amp; Son Abingdon, Maryland.</i>				<b>DATE</b> <i>FEB 23 '62</i>			

VR A15 (4)  
15M 9/60



01910

01908

(M)

Howard K. McCombs & Son Abingdon, Maryland.  
Feb. 1, 1901  
Rev. Sir

Bal. 11, H. 1770, Maryland



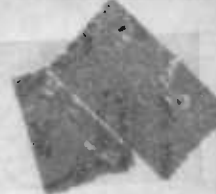
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01969 CERTIFICATE OF DEATH 01950

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Prov. Ground</b>				c. LENGTH OF STAY IN Ib <b>13 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US Army Hospital</b>				d. STREET ADDRESS <b>#1 Rigdon Road</b>			
3. NAME OF DECEASED (Type or print) <b>MARY M. WALSH</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>Cauc</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>12/25/1893</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA Naturalized</b>			
13. FATHER'S NAME <b>John Dooner</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Thomas Walsh Jr (Son)</b>				Address <b>#1 Rigdon Rd. Aberdeen, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>							
443X DUE TO (b) <b>Congestive Heart Failure</b>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Hypertensive and Arteriosclerotic Heart Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>							
2 weeks <b>Several years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that <b>20</b> (this hospital) attended the deceased from <b>February 14, 1962</b> to <b>February 27, 1962</b> that (I) (we) last saw the deceased alive on <b>February 27, 1962</b> , and that death occurred at <b>9:20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Albert Frankel</b>							
22b. DATE SIGNED <b>February 27, 1962</b>							
22c. PHYSICIAN'S NAME (Type) <b>ALBERT FRANKEL, Captain, MC</b>							
22d. ADDRESS <b>US Army Hospital, Aberdeen Prov Gd., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
23b. DATE THEREOF <b>3/3/1962</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens - Bel Air Maryland</b>							
23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tanning Funeral Home - Aberdeen, Md.</b>							
25a. REC'D BY REGISTRAR <b>MAR 5 '62</b>							
25b. REGISTRAR'S SIGNATURE <b>Albert S. Thomas</b>							

01333

01333



Handwritten text, mostly illegible due to blurring and bleed-through. Some words like "University" and "Department" are faintly visible.

Handwritten text at the bottom of the page, including what appears to be a date "February 11, 1963" and a signature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
#

01970

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01951

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>1 hr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace Md</u> d. STREET ADDRESS <u>301 So. Union Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. PLACE OF BIRTH (County & State, or foreign country) <u>Principio Md.</u>	
13. FATHER'S NAME <u>Theodore Watts</u>		14. MOTHER'S MAIDEN NAME <u>Mary Busher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Margaret H. Watts</u>		Address <u>306 S. Union Ave. Havre de Grace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>11 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary arteriosclerosis + Chronic bronchitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>e.m.</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1st, 1961</u> to <u>Feb 5th, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 5th, 1962</u> and that death occurred at <u>10:55 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell C. Loo</u> M.D.		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/1/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Elin</u>	23d. LOCATION (City, town or county) (State) <u>Havre de Grace Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pruntylu Pm, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 7 '62</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Fennell</u>	

16810

01070

(M)

(1)

VS. A15M  
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon Rural</u>		c. LENGTH OF STAY IN lb <u>12 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche M. Wherry</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-12</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
13. FATHER'S NAME <u>Isaiah Like</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Shrubb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Thomas C. Wherry</u>		Address <u>Abingdon Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-6-62</u>	
Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 8, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or country) (State) <u>Bel Air, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR <u>Howard K. Me Comas &amp; Son</u>		24a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>Abingdon Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>FEB 9 '62</u>			



01835

M

Howard R. McCombs & Son  
3141 Memorial Drive  
Baltimore, Maryland